

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/12/2019
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 GUNTER ROAD FLORENCE, MS 39073		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, CI MS# 16289 and a revisit to the annual survey on 11/12/19/ The SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA was able to substantiate the allegations of Misappropriation of Property, however no deficiencies were cited. Facility Census 53/Licensed Beds 60	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE